In The United States District Court
For The Eastern District of Pennsylvania

William Clinton Haemon
Clindora Haemon

vs.

Maryland Dept. of Health And Mental Hygiene et Al

Civil Action No. 13-0504

2/12/13

Motion

Your honorable Judge Mr. Paul S. Diamond, My Name is William C Haemon. One of the plaintiffs In Case No 13-0504 that I am hoping to have you decide the out come of. My mother in this matter is 91 yrs old. She has some Serious health issue's Dementia, Lewy bodies disease, an her memory is not that good. I am the Executor & power of Attorney of those affairs that she does not under Stand. I want to Ask you to Reconsider in this matter an Remove the stade from her name an allow me to represent her going forward please. Here are my papers to show you that I had Lawyer's from my home in Virginia to draw up for us some time ago. I strongly feel that Injustice was done to us in this matter. No one should have to learn what was done to there Love ones, or for there Love one after he is dead

William C Haemon

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

WILLIAM CLINTON HARMON **CLINDORA HARMON**	:	**CIVIL ACTION**
v.	:	
MARYLAND DEPT. OF HEALTH AND MENTAL HYGIENE, et al.	:	**NO. 13-0504**

FILED FEB 05 2013

O R D E R

AND NOW, this 5th day of February, 2013, upon consideration of the motion to proceed in forma pauperis filed by co-plaintiff, William Clinton Harmon, it is hereby ORDERED that:

1. The motion for leave to proceed in forma pauperis filed by co-plaintiff, William Clinton Harmon, is **DENIED** because he has sufficient assets to enable him to pay the full $350.00 filing fee for this civil action. Paid on 2/12/13 $350.00

2. Co-plaintiff, Clindora Harmon, is **DISMISSED** as a party to this civil action because she has failed to sign the complaint, and to either pay the $350 filing fee to commence this civil action or to file a motion to proceed in forma pauperis. The Clerk of Court shall amend the docket to **STRIKE** her name from the caption of the complaint; and I represent my mother

3. The Clerk of Court shall mark this case **CLOSED** statistically.

BY THE COURT:

/s/ Paul S. Diamond

PAUL S. DIAMOND, J.

DURABLE GENERAL POWER OF ATTORNEY

I, Clindora Harmon presently of 12499 Shell Bridge Road, Painter, Accomack County, Virginia 23420, do hereby appoint my children, William C. Harmon, Lee Rome Harmon and Berneda V. Harmon, either or whom may act alone, to serve as my agent under this general power of attorney, hereby authorized to exercise the following powers in my behalf.

(1) to request, receive, sue for, and recover from all persons, corporations, associations or other entities (i) each and every parcel of realty and article of personalty that I own or am entitled to possess, and (ii) each and every sum of money, claim, or right, due and owing, or that may become due and owing, to me on any and every account, contract or tort, in my agent's discretion, to arbitrate or compromise therefore;

(2) to withdraw from or close my accounts or deposits in banks or other financial institutions;

(3) to sign any deed, contract, court order, pleading, retirement or disability election, or any other paper;

(4) to borrow money in my name on such terms as my agent may deem appropriate, and to execute notes and any documents necessary to give any lender a security interest in any or all of my real estate and/or personal property in connection with any loan;

(5) to sell or lease any part or parts of my real or personal estate, or any interest which I may have in any real or personal estate, wherever situated, upon such terms as my agent may deem appropriate, and to make all necessary deeds and conveyances thereof, with all necessary covenants, warranties and assurances, and to sign, seal and acknowledge and deliver the same;

(6) to buy or sell stocks, bonds, treasury securities, or other investments on my behalf in accordance with the "prudent man" rule;

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(7) to enter any safe deposit box that I may be the lessee of, or otherwise entitled to enter, and to remove or add to its contents;

(8)to borrow against or obtain the cash surrender value of any of my life insurance policies, and to transfer the ownership of any policies to the primary beneficiary(s) named therein;

(9)to create, and to add to, intervivos trusts for my benefit;

(10) to make gifts to beneficiaries named in my will by way of total or partial satisfaction of bequests, legacies or devisees made to such beneficiaries in my will, as written at the time of such gifts; and

(11) to make allocations of money and property to income or principal; to insure activities; to sign and file Federal, State and local tax returns and forms and pay and compromise for taxes, and to conduct and consent to tax elections and audits, and receive tax documents and refunds, including without limitation the consent required under IRS Sec.2513;

(12) to operate all kinds of businesses and to employ and discharge agents and professionals, contractors and employees;

(13) to do all such other acts, matters or things in relation to all or any part of, or interest in, my property, affairs or business of any kind, or description in the State of Virginia, or elsewhere, that I could do if acting personally.

Pursuant to §11-9.1 of the Code of Virginia of 1950, as amended, this power of attorney shall not terminate upon my becoming disabled or incapacitated and all power and authority vested in my agent shall continue and be exercisable by such agent notwithstanding that I may subsequently become disabled, incompetent or incapacitated and all acts done by my agent pursuant to said power and authority during the period of any such disability, incompetence or incapacity, shall have in all respects the same effect and shall inure to the

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DURABLE MEDICAL POWER OF ATTORNEY/ADVANCE MEDICAL DIRECTIVE

OF

CLINDORA HARMON

I, CLINDORA HARMON, willfully and voluntarily make known my desire and do hereby declare:

If at any time, my attending physician should determine that I have a terminal condition where the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or alleviate pain.

In the absence of my ability to give directions regarding the use of such life-prolonging procedures if I have a terminal condition, it is my intention that this Advance Medical Directive shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

I hereby appoint my children, WILLIAM C. HARMON, LEE ROME HARMON and BERNEDA V. HARMON, either or whom may act alone, as my agent to make health care decisions on my behalf as authorized in this document.

I hereby grant to my agent, named above, full power and authority to make health care decisions on my behalf, as described below, whenever I have been determined to be incapable of making an informed decision about providing, withholding or withdrawing medical treatment. The phrase "incapable of making an informed decision" means unable to understand the nature, extent and probable consequences of a proposed medical decision or unable to make a rational evaluation of the risks and benefits of alternatives to that decision, or

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unable to communicate such understanding in any way. My Agent's authority hereunder is effective as long as I am incapable of making an informed decision.

The determination that I am incapable of making an informed decision shall be made by my attending physician and a second physician or licensed clinical psychologist after a personal examination of me and shall be certified in writing. Such certification shall be required before treatment is withheld or withdrawn, and before, or as soon as reasonable practicable after, treatment is provided, and every One Hundred Eighty (180) days thereafter while the treatment continues.

In exercising the power to make health care decisions on my behalf, my agent shall follow my desires and preferences as stated in this document or as otherwise known to my agent. My agent shall be guided by my medical diagnosis and prognosis and any information provided by my physician as to the intrusiveness, pain, risks and side-effects associated with treatment or nontreatment. My agent shall not authorize a course of treatment which he knows, or upon reasonable inquiry ought to know, is contrary to my religious beliefs or my basic values, whether expressed orally or in writing. If my agent cannot determine what treatment choice I would have made on my own behalf, then my agent shall make a choice for me based upon what he believes to be in my best interests.

The powers to my agent shall include the following:

(A) to consent to or refuse or withdraw consent to any type of medical care, treatment, surgical procedure, diagnostic procedure, medication and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, artificially administered nutrition and hydration, and cardiopulmonary resuscitation. This authorization specifically includes the power to

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consent to the administration of dosages of pain-relieving medication in excess of standard dosages in an amount sufficient to relieve pain, even if such medication carries a risk of addiction or inadvertently hastens my death;

(B) To request, receive, and review any information , verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information;

(C) To employ and discharge my health care providers;

(D) To authorize my admission to or discharge (including transfer to another facility) from any hospital, hospice, nursing home, adult home or other medical care facility; and

(E) To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

Further, I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services, to give, disclose, and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

A) The authority given to my agent shall supersede any prior agreement that I may have made with my health care providers

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to restrict access to or disclosure of my individually identifiable health information.

B) The authority given to my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

In addition to the other powers granted by this document, I grant to my agent the power and authority to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and its regulations (HIPAA) during any time that my agent (hereinafter referred to in subsequent clauses of this paragraph as my"HIPAA personal representative") is exercising power under this document.

A) Pursuant to HIPAA, I specifically authorize my HIPAA personal representative: to request, receive and review any information regarding my physical or mental health, including without limitation all HIPAA-protected health information, medical and hospital records; to execute on my behalf any authorizations, releases, or other documents that may be required in order to obtain this information and to consent to the disclosure of this information. I further authorize my HIPAA personal representative to execute on my behalf any documents necessary or desirable to implement the health care decisions that my HIPAA personal representative is authorized to make under this document.

B) By signing this document, I specifically authorize my physician, hospital or health care provider to release any and all medical records to my HIPAA personal representative or to my representative's designee.

Further, my agent shall not be liable for the costs of treatment pursuant to his authorization, based solely on that authorization.

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This Advance Medical Directive shall not terminate in the event of my disability.

By signing below, I indicate that I am emotionally and mentally competent to make this Advance Medical Directive and that I understand the purpose and effect of this document.

Dated this 21st day of August, 2009.

Clindora Harmon (SEAL)
CLINDORA HARMON

The declarant signed the foregoing Advance Medical Directive in my presence. I am not the spouse or blood relative of the declarant.

Witness

Witness

{wills.Harmon,Clindora,amd}

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